

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Patient's Access to Physician's Records

TO THE EDITOR: I liked your editorial in the September issue, "Patient's Access to Physician's Records," even though you come out on the opposite side from me.¹ I think you are certainly right about the possibility of patients misinterpreting data and terms, for instance, but I wonder if giving them their records wouldn't result in a more informed public, and one more respectful of their own limitations, in time. I also share your attitude toward third parties, who are likely to respect the rights of neither patient nor doctor.

In general, though, I think we are in a new age, and people will be less and less willing to take things on faith, from a doctor or anyone else. In a lot of ways this is too bad, but I'm afraid that's the way it is. If we as physicians keep things to ourselves, I think the general tide of society will believe less and less that we do it for their benefit. Therefore, I think it is up to us to make the records available, but take steps to ensure that good results do come of it.

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REFERENCES

1. Shenkin BN, Warner DC: Giving the patient his medical record: A proposal to improve the system (Sounding Board). *N Engl J Med* 289:688-698, Sep 27, 1973

Patients at Risk for Postoperative Pulmonary Embolism

TO THE EDITOR: A method for identifying patients at risk for postoperative pulmonary embolism has been developed at this institution. It requires the correlation of patient body surface area and anesthesia time and proved reliable in both prospective and retrospective studies. This system can be used to identify at-risk patients preoperatively, thus providing a more rational use for preopera-

tive and postoperative scanning as well as for heparin prophylaxis.

Patient body surface area is calculated in square meters and multiplied by anesthesia minutes (as opposed to surgical minutes) to give a surface area—anesthesia minutes value (SAM). By way of example, the SAM value of a patient may be calculated as follows:

$$\text{Surface Area} \times \text{Anesthesia Minutes} = \text{SAM Value} \\ 1.821 \text{ m}^2 \times 120 \text{ minutes} = 218 \text{ SAM}$$

The SAM values and the incidence of pulmonary embolism in a prospective study of 40 abdominal and 30 extra-abdominal cases are shown in Table 1. Note that as the SAM values increase so does the incidence of pulmonary embolism. Patients become at risk for embolism in abdominal procedures at SAM values of 300 or more and at risk in extra-abdominal procedures at SAM values of 400 or more.

TABLE 1.—SAM Values and Incidence of Pulmonary Embolism for Abdominal and Extra-abdominal Procedures

Abdominal		Extra-abdominal	
SAM Values	Incidence (Percent)	SAM Values	Incidence (Percent)
<200	10	<200	0
200-300	15	200-400	5
300-400	30	>400	12.5
>400	43		

The various studies have reported asymptomatic pulmonary emboli up to 20 percent.^{1,2} In the study conducted here, the incidence of asymptomatic pulmonary emboli was 22 percent in the abdominal group and 3 percent in the extra-abdominal group. The relationship between patient size and anesthesia time proved to be reliable in predicting postoperative embolic events. Anesthesia time is important as the very nature of surgical operations produces a state of hypercoagulability and as anesthesia time lengthens, the opportunity increases for activated clotting components to unite. Patient size is more difficult to